WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid, BadgerCare, or SeniorCare to make a reasonable judgement about the case. Prescribers and dispensing physicians are required to retain a completed copy of the form.

When using the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, prescribers are required to complete and sign the form. Dispensing providers (e.g., pharmacies, dispensing physicians, federally qualified health centers, blood banks) must use the PA/PDL Exemption Request to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. For STAT-PA requests, dispensing providers should call (800) 947-1197 or (608) 221-2096. Dispensing providers may submit paper PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Dispensing providers who wish to submit paper PA requests by mail may do so by submitting a Prior Authorization Request Form (PA/RF) and a PA/PDL Exemption Request to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 8, 1996, would be 09/08/1996).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 4 — Drug Name
Enter the drug name.

Element 5 — Strength
Enter the strength of the drug listed in Element 4.

Element 6 — Date Prescription Written
Enter the date the prescription was written.

Element 7 — Directions for Use
Enter the directions for use of the drug.

Element 8 — Diagnosis — Primary Code and/or Description
Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug or biologic requested. The ICD-9-CM diagnosis code must match the ICD-9-CM description.

Element 9 — Name — Prescriber
Enter the name of the prescriber.

Element 10 — Drug Enforcement Agency Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

XX5555555 — Prescriber's DEA number cannot be obtained.
XX9999991 — Prescriber does not have a DEA number.

These default codes must *not* be used for prescriptions for controlled substances.

Element 11 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code.

Element 12 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION

Include diagnostic, as well as clinical information, explaining the need for the product requested. In Elements 13 through 16, check "yes" to all that apply.

Element 13
Check the appropriate box to indicate if the recipient has experienced treatment failure with the preferred product(s). If yes, indicate the failed drug(s) and the dates the drug(s) was taken.

Element 14
Check the appropriate box to indicate if the recipient has a condition(s) preventing the use of the preferred product(s). If yes, indicate the condition(s) the recipient experienced that prevent the use of the preferred product(s).

Element 15
Check the appropriate box to indicate if there is a clinically significant drug interaction between another medication the recipient is taking and the preferred product(s). If yes, indicate the medication interaction experienced.

Element 16
Check the appropriate box to indicate if the recipient has experienced intolerable side effects while on the preferred product(s). If yes, indicate the intolerable side effects the recipient experienced.

Element 17 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 18 — Date Signed
Enter the month, day, and year the PA/PDL Exemption Request was signed (in MM/DD/YYYY format).

SECTION IV — FOR DISPENSING PROVIDERS USING STAT-PA

Element 19 — National Drug Code
Enter the appropriate 11-digit National Drug Code (NDC) code for each drug or biologic.

Element 20 — Days' Supply Requested
Enter the requested days' supply.

Element 21 — Wisconsin Medicaid Provider Identification Number
Enter the provider's eight-digit Wisconsin Medicaid provider identification number.

Element 22 — Date of Service
Enter the requested first date of service for the drug or biologic. For STAT-PA requests, the date of service may be up to 31 days in the future or up to four days in the past.

Element 23 — Place of Service
Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
00	Not specified
01	Home
04	Long Term/Extended care
07	Skilled Care Facility
10	Outpatient

Element 24 — Assigned Prior Authorization Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 25 — Grant Date
Record the date the PA was approved by the STAT-PA system.

Element 26 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 27 — Number of Days Approved
Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 28
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may also be included here.